

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011737
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 606

FILED MAR 18 1959
OFFICE OF DEATH

300
-57

a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>University City</u> 4376 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>		Length of stay in 1b <u>days</u>	d. STREET ADDRESS (If outside, give location) <u>8042 Gannon Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>A</u> Last <u>Vedder</u>			4. DATE OF DEATH Month <u>March</u> Day <u>4th</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 20-1881</u>	9. AGE (In years last birthday) <u>77</u>	10. FUNDER 1 YEAR Months <u>7</u> Days <u>7</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Ass't. Vice Pres. Bell Telephone</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone</u>	11. BIRTHPLACE (City and state or country) <u>Batavia, N.Y.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>unk Vedder</u>	13b. MOTHER'S MAIDEN NAME <u>unk</u>	14. NAME OF HUSBAND OR WIFE <u>Edna M. Vedder</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT <u>Mrs. Edna M. Vedder 8042 Gannon Ave. Mo.</u> Address <u>University City</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage - upper Gastro-Intestinal</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Melanomatosis</u>		<u>several months</u>
	DUE TO (c) <u>Melanoma of Eye</u>		<u>3 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>192x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u>8:45</u> a.m. <u>p.m.</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>University City</u>	COUNTY <u>Mo.</u>	STATE <u>Mo.</u>
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21. I attended the deceased from <u>2-2-59</u> to <u>3-4-59</u> and last saw ^{him} <u>him</u> alive on <u>3-4-59</u> Death occurred at <u>8:45 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Daniel J. Hepler</u> M.D.	22b. ADDRESS <u>Missouri Theater Bld'g.</u>	22c. DATE SIGNED <u>3/5/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-7-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>
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24. FUNERAL DIRECTOR <u>C.R. Lupton and Sons 7233 Delmar Blv'd.</u>	ADDRESS <u>7233 Delmar Blv'd.</u>	25. DATE RECEIVED BY LOCAL REG. <u>3-5-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy, M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

CHAS. A.
LETTER
(COUNTY USE)

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Arnold W. Schene

Licensed Embalmer No. 3864

P. O. Address St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.